Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
March 19, 2003

Hearing on the Availability and Eligibility for Pharmaceutical Services Provided by the Department of Veterans Affairs

Question 1: Since the Veterans Health Administration (VHA) is already permitting private prescriptions to be filled for a limited group of veterans (those with housebound benefits in state home, for example), would it not be possible to expand the benefit to include other enrolled veterans?

Response: Yes, it would be possible for VA to expand the benefit to other enrolled veterans. Please see our response to question 11 for details on VA's new Transitional Pharmacy Benefit program.

Question 2: Dr. Roswell remarked during the hearing that the report of VA's Inspector General, *Audit of VHA Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans*, has been referred to the National Leadership Board for review. Please provide the Subcommittee a report of the status of that review, along with VA's planned actions.

Response: The Under Secretary for Health referred the OIG's original 2000 report, the OIG's new draft update, and a VHA commentary on the methodology used to calculate savings to the VHA National Leadership Board (NLB) for consideration. The Executive Committee of the NLB recommended that the OIG consider revising the report and obtain guidance from VHA on successful methodologies for financial evaluations of healthcare.

VHA has met with the OIG to discuss the methodology used for both reports. VHA explained its concerns about the methodology used, including the failure of the OIG to consider possible increased demand for (prescription) services in its costing model. VHA provided written suggestions and data to the OIG to assist them in the review of their own calculations. OIG continues to re-examine its updated report.

Question 3: The Department of Defense (DoD) military health system processes prescriptions from non-DoD providers under the TRICARE program. Please describe the reasons that VA cannot establish a prescription drug program similar to the one available in the DoD structure.

Response: There are several reasons why VA cannot or should not establish a prescription drug program similar to the one available in the DoD structure. First,

the Departments are funded differently. DoD TRICARE is an entitlement program, while VA health care is a discretionary benefit. Prescription-benefit funding in DoD is commensurate with workload demand while, in VA, there is a risk that funding for an expanded benefit would need to be diverted from existing medical care programs if adequate additional resources for a prescription only benefit are not made available.

Second, VA medical care has historically been defined by the provision of *comprehensive* health care services for veterans. One of the many benefits offered to veterans as part of VA's comprehensive health care system is a robust prescription benefit. VA has maintained control over the costs of its prescription benefit by using sophisticated formulary management techniques and by assuring that prescriptions written by VA staff are consistent with the goals of the formulary management process. This comprehensive model of health care has allowed the VA to manage patient care in its entirety and ensure that the veteran is receiving optimal cost effective and safe care.

Third, VA's drug management practices are not included in DoD's TRICARE prescription program and, as a result, DoD's costs are considerably higher than VA's. In VA, a single primary care provider coordinates drug therapy. The TRICARE health care system has several different venues of care that can occur in the Medical Treatment Facilities (MTFs) or the TRICARE health care network. The pharmacy benefit and co-pays vary and are based not only on trade vs. generic pharmaceuticals, but also on the points of service. A TRICARE member has three means to fill a prescription, the MTFs, the TRICARE retail pharmacy network and the TRICARE Mail Order Pharmacy (TMOP). Each of these venues has a different method for managing the pharmacy benefit. In addition to the co-payment structure and the selection of a trade brand vs. a generic brand, the MTF is the only point-of-service that utilizes DoD's basic core formulary.

Question 4: What is the status of the requirement in PL 107-314 that requires VA and DoD to develop a joint pharmacy data transaction tracking system?

Response: VA and DOD are jointly implementing a plan that will provide the capability to exchange pharmacy data transactions between DOD's CHCS II (Composite Health Care System) and VA's Health**e**Vet strategy for VistA (Health**e**Vet-VistA) by FY 2004. VA and DOD will have the capability to perform comprehensive automatic drug interaction checks using medication information from VA and DOD facilities and mail order operations and DOD's network pharmacies. This interoperability will provide the two Departments the capability to perform checks on drug interactions and duplicate drug class orders that are available in DOD's Pharmacy Data Transaction Service. It will allow the Agencies to perform the clinically important drug allergy and drug adverse event checks as well.

The following chart provides current status, including major milestones and completion or target dates.

Implementation Plan:	Target Dates:	Status:
Health Data Repository (HDR) Functional Requirements Defined	May 02	Completed
HDR Mapping Strategy Defined	December 02	Completed
Technical, Acquisition, and Implementation Strategies Defined	January 03	Completed
Testing of Installed Network, Hardware, Software	June 03	Completed
Demonstrate Interoperability between VA and DoD Pharmacy Information Systems	July 04	

Question 5: Concerns have been raised about the need to ensure that medications are properly and effectively used by the patients. Is this a legitimate concern, and why?

Response: The safe and effective use of medications is the cornerstone of modern health care and is of paramount importance. VA strongly believes that drug therapy must be coordinated, monitored, and managed by a single primary care provider. Drugs are a major cause of iatrogenic injury and adverse drug events (ADEs). Many ADEs are associated with medication errors and are thus preventable.

VA has experience demonstrating that providing pharmaceuticals as an integrated portion of a comprehensive health care benefit is effective and efficient. VA's clinical pharmacists are members of VA's primary care teams. VA clinical pharmacists, with a scope of practice authority, have the ability to initiate, modify, continue and monitor a patient's drug therapy under protocols. VA has established progressive pharmacy practice models to demonstrate improved patient outcomes and maximize the pharmacist's contributions to drug therapy within a primary care team. Many improvements have been realized and supported by advanced computerized and automated systems, expanded disease state management practices, and unique practitioner and administrative support.

Question 6: Could these worries be resolved through the implementation of a medication management program that would include credentialing of non-VA health care providers eligible to write prescriptions, drug utilization reviews and a call center to respond to patient-specific medication questions?

Response: Not entirely. While a medication management program as described above would be helpful, it would not include key components of VA's current system such as coordination of care, concurrent drug utilization management, adherence to prescribing guidelines, management of outcomes, polypharmacy, and reporting and management of adverse events.

If VA provided a prescription only service, the pharmacist could still provide 1) counseling on new prescriptions; 2) verification for the appropriate drug dosage and instructions; 3) alerts to private physicians for any known drug interaction, drug allergy, or drug duplication; and 4) calls to providers to confirm any illegible prescription. However, these activities do not provide oversight for the safe, cost-effective use of medications, beyond the appropriate prescribing of a single medication. The pharmacist would not be able to monitor the outcome of prescribing to reach a therapeutic goal or to monitor side effects. The effective use of medications would be the sole responsibility of the prescribing private physician.

Question 7: As we have seen in the past with other federal benefits (such as the rapid rise in spending that resulted from the inception of a Medicare home health care benefit in the 1980's) the liberalization of a VA prescription drug benefit could result in inappropriate use and over-utilization. What key elements would be necessary for VA to design into a "prescription only" benefit to prevent fraud and abuse?

Response: There is no clear single solution or foolproof means to preventing fraud and abuse, inappropriate use, and over-utilization. However, special attention would need to be devoted to such things as verifying patient/provider relationships, verifying patient eligibility, monitoring individual patient prescription utilization patterns, duplicate drug checking (duplicate drug class checking, early refills, controlled substances utilization, etc.), and attempting to match drug therapy with a patient's know diagnoses.

Question 8: The RAND Insurance study from the 1970's is the classic means of determining cost in health care utilization. Those who rely on the RAND study have suggested, in effect, "if you build it, they will come." Certainly this has been true with VA's experience with CBOCs. Would the same be true for any bill that authorizes VA to serve as a pharmacy-only benefit to veterans, and why?

Response: VHA believes that high demand is a possibility. Increasingly, prescription pharmaceuticals are being relied upon more and more as the single most effective means to extend life and improve the quality of life for individuals suffering from disease. However, pharmaceuticals are expensive, and many people do not have affordable access to prescription drugs. In the absence of Medicare Drug Benefit, older Americans are especially disadvantaged inasmuch as they, as a group, are among the highest users of pharmaceuticals, but are

often unable to afford to pay for them. As a result, older Americans who are veterans and do not have affordable access to prescription drugs, represent a large group who could turn to VA if an expanded pharmacy benefit is provided.

Over 8 million veterans are eligible for Medicare. It is possible that all Medicare-eligible veterans not currently seeking VA care would consider a pharmacy-only benefit, if it were affordable and convenient. Thus, the projected number of veterans over 65 without a prescription benefit who might seek a pharmacy-only benefit could be nearly twice the current number of enrolled veterans.

Question 9: You stated in your testimony that a pharmacy-only benefit would "constitute an expanded service that, without additional new funding, would tend to erode the comprehensive medical care benefits that veteran users of the VA health care system now enjoy." However, the VA currently spends a significant amount of funds on re-examining, re-testing, and re-writing prescriptions that veterans obtain form their private health care providers, many if not most are approved Medicare providers. Is it not reasonable to assume that the resources saved by eliminating this duplication of health care services could help the VA to do a better job at maximizing the quality of care of other enrolled veterans?

Response: There is no empirical data on the extent to which VA would be able to redirect funds spent on some medical services that might be avoided if a prescription-only benefit was available. Because of this, we have strong reservations about implementing such a program and are concerned about the unintended consequences of significantly increased demand if such a program was made available. Specifically, we believe the offset may not cover the additional costs of an expanded benefit and that the cost savings that might accrue from eliminating some medical services could be consumed by the increase in demand generated by a permanent, unlimited prescription-only benefit. If that is the case, not only would additional resources not be available for use in other areas of medical care, but there is also the possibility that the quality of care in other areas may be compromised by a diversion of resources resulting from significantly increased demand from a prescription-only program.

Question 10: You indicated in your testimony that waiting times and the need for prescription drugs are unrelated. Wouldn't you agree that some of those veterans waiting for an appointment are actually waiting to have a prescription written for them, or are holding prescriptions written by other providers outside the VA that they wish VA to provide?

Response: VA recognizes that provision of medications, as a component of its comprehensive medical benefits package, is a strong incentive for many veterans to seek health care from VA. We agree that some veterans on current waiting lists have prescriptions written by non-VA providers and are waiting for VA care primarily in order to receive medications at lower cost from VA. However, as we stated above in response to question 9, an analysis of the

utilization of new enrollees who indicated in the VHA New Enrollee Survey that pharmacy access was their primary reason for enrollment shows that their use of services was not limited to primary care and pharmacy.

Question 11: Please provide the Subcommittee an outline of the "administrative" prescription benefit that you summarized in your testimony.

Response: VA has developed a program to provide a time-limited prescription benefit to patients who have enrolled in VA, requested a primary care visit, and are waiting for a visit greater than 30 days. On July 24, 2003, I announced the formation of this Transitional Pharmacy Benefit program. An interim final regulation governing provision of the benefit was published in the Federal Register on July 25, 2003.

The new Transitional Pharmacy Benefit was developed to help veterans reduce the out-of-pocket medication expenses they incur while waiting for a primary care visit with VA. To be eligible for this time-limited benefit, veterans must meet all of the following conditions:

- They must have enrolled in the VA health care system before July 25, 2003.
- They must have requested their first primary care appointments with VA before July 25, 2003.
- As of September 22, 2003, they must be waiting more than 30 days for their first appointments with a primary care physician.

On September 22, 2003, VA began to accept prescriptions from Transitional Pharmacy Benefit participants and also began to collect cost, utilization and service quality data. Data will be collected at the end of each week and those data will be used to prepare program summary reports. VA will also monitor and evaluate the impact of the program on its current and future budgets and on its primary mission of providing health care to veterans. VA is continuing to explore other options for the provision of a prescription benefit and, in doing so, is carefully examining all legal, clinical, operational, and economic consequences of such proposed policies.